Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DEC OF TEXAS, INC.
601 TEXAS TRAIL, SUITE 201
CORPUS CHRISTI, TEXAS 78411

Respondent Name

ACE AMERICAN INSURANCE CO

Carrier's Austin Representative Box

Box Number 15

MFDR Tracking Number

M4-11-2326-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This was a Post DD-RME for MMI & IR. This was scheduled at the request of the adjuster through their attorney. As of today's date I have send a Request for Reconsideration to no avail. I set Bill Review a copy of the Guides illustrating the correct maximum allowable charge. This claimant was at MMI-$350.00 had 2 body areas- 1st with ROM so $300.00, 2nd DRE so $ 150.00. Total allowable $ 950.00. As of today's date there is still an outsanding balance of $300.00. Requesting assistance from Dispute Resolution in getting the $300.00 owed to Dr. Keendy plus interest."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: A copy of dispute was placed in carrier rep box on March 14, 2010 with no response to MFDR.

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 9, 2010	99456-WP	$300.00	$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated August 25, 2010
   - W1 – Workers' Compensation State Fee Schedule Adj

   Explanation of benefits dated September 21, 2010
   - W1 – Workers' Compensation State Fee Schedule Adj
   - W3 – Additional payment on appeal/reconsideration
   - ORC – See Additional Information
   - Lumbar area not addressed as the lumbar is not related

   Explanation of benefits dated March 22, 2010
   - 97A – Provider appeal
   - W3 – Additional payment on appeal/reconsideration
   - ORC – See Additional Information

Issues

1. Has the examination for Maximum Medical Improvement (MMI)/Impairment Rating (IR) been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement for the services in dispute under 28 Texas Administrative Code §134.204?

Findings

1. According to the explanation of benefits dated September 21, 2010 with denial code "ORC – See additional information" and the bill comment, "lumbar area not addressed as the lumbar is not related." These reflect diagnoses/condition compensability and relatedness issues. Upon reconsideration, these denial reasons were not maintained as indicated on the March 22, 2011 Post MFDR EOB. There is no Plain Language Notice (PLN-11) on file regarding the diagnoses codes 310.2 POSTCONCUSSION SYNDROME, 719.41 PAIN IN JOINT, SHOULDER REGION, and 724.2 LUMBAGO. MDFR will proceed with audit per applicable fee guidelines.
2. The provider billed the amount of $950.00 for CPT code 99456-WP for Maximum Medical Improvement/Impairment Rating (MMI/IR) for a post Designated Doctor (DD) carrier requested Required Medical Examination (RME). Review of the documentation supports that MMI was assigned. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. The documentation supports also that three body areas were rated for impairment. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a), the MAR for a 1st musculoskeletal area IR using Range of Motion (ROM) on right shoulder (upper extremities) is $300.00. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I), the MAR for an IR using Diagnosis Related Estimates (DRE) method on lumbar spinal region is $150.00. Per 28 Texas Administrative Code §134.204(j)(4)(D)(v), the MAR for an IR using DRE on a non-musculoskeletal post concussion syndrome is $150.00. The combined MAR for the MMI/IR services rendered is $950.00.
3. Review of the payments shows that requestor was reimbursed $500.00 on the August 25, 2010 audit, $150.00 on the September 21, 2010 audit, and an additional $150.00 on the March 22, 2011 post MFDR audit. The combined MAR for the documented MMI/IR services rendered is $950.00. The respondent has to date paid $800.00. Therefore, the requestor is entitled to additional reimbursement of $150.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the additional amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 21, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.